Exhibit A

FRAN KUMMERFELDT 00-475K3
MICHAEL S. LIBOCK, CPA, LLC
349 KINDERKAMACK RD
WESTWOOD, NJ 07675

9814 49

HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY **PLANS B, C, D, E**

SMALL GROUP HEALTH BENEFITS POLICY

POLICYHOLDER: MICHAEL S. LIBOCK, CPA, LLC

GROUP POLICY NUMBER	GOVERNING JURISDICTION	EFFECTIVE DATE OF POLICY
475K3-00	NEW JERSEY	JULY 1, 2011

POLICY ANNIVERSARIES: July 1 of each Year, beginning in 2012.
PREMIUM DUE DATES: Monthly
AFFILIATED COMPANIES: **None**

Horizon Blue Cross Blue Shield of New Jersey in consideration of the application for this Policy and of the payment of premiums as stated herein, agrees to pay benefits in accordance with and subject to the terms of this Policy. This Policy is delivered in the jurisdiction specified above and is governed by the laws thereof.

The provisions set forth on the following pages constitute this Policy.

The Effective Date is specified above.

This Policy takes effect on the Effective Date, if it is duly attested below. It continues as long as the required premiums are paid, unless it ends as described in the **General Provisions** section.

Horizon Healthcare Services, Inc. d/b/a
Horizon Blue Cross Blue Shield of New Jersey
By:

Al Bowles

Al Bowles
Vice President
Commercial and Major Account Markets

Policy Holder's Name:

MICHAEL S. LIBOCK, CPA, LLC

Authorized Signature:

_____

Title:_____ Date:_____

POLICY INDEX

SCHEDULE OF INSURANCE AND PREMIUM RATES **POS PLAN B**

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

CLASS: All Eligible Employees
Applicable to Sub Group 00

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

For Preventive Care	NONE

For all other treatment, services and supplies given by a **Network** Provider (other than for Preventive Care):

Visits for Therapeutic Manipulation	$30
Visits for Therapy Services	$30
Maternity (Pre-natal care)	$25 for initial visit only.
All Other Physician Visits	$20

Emergency Room Copayment, (waived if admitted within 24 hours)	$100

Note: The Emergency Room Copayment is payable in addition to the applicable Copayment, Deductible and Coinsurance.

Calendar Year Cash Deductible - For treatment, services and supplies given by a Non-Network Provider, and for Prescription Drugs:

for Preventive Care	None
for immunizations and lead screening for children	None
for all other Covered Charges	
Per Covered Person	$2,500
Per Covered Family:	$5,000 **Note**: Must be individually satisfied by two separate Covered Persons.

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, Horizon BCBSNJ will waive the Coinsurance requirement once Network Maximum Out of Pocket has been reached with respect to Network services and supplies, and Horizon BCBSNJ will waive the Coinsurance requirement once the Non-Network Maximum Out of Pocket has been reached with respect to Non-Network services and supplies. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Coinsurance** for this Policy is as follows:

For Preventive Care:	0%
For all other services and supplies:	
if treatment, services or supplies are given by a Network Provider	None, **except as stated below**
if treatment, services or supplies are given by a Non-Network Provider	40%, **except as stated below**

Exception:
The Coinsurance for Prescription Drugs does not vary according to use of a Network Provider or a Non-Network Provider.

The Coinsurance for Prescription Drugs is:	40%.

Network Maximum Out of Pocket

Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Network covered services and supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Network Maximum Out of Pocket. Once the Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network covered services and supplies for the remainder of the Calendar Year.

The **Maximum Out of Pocket** for this Policy is as follows:

Per Covered Person per Calendar Year	$3,000
Per Covered Family per Calendar Year	$6,000

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges.

Non-Network Maximum Out of Pocket

Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Non-Network covered services and supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. Once the Non-Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as

Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.

The **Non Network Maximum Out of Pocket** for this Policy is as follows:

Per Covered Person per Calendar Year	$7,500
Per Covered Family per Calendar Year	$15,000

Note: The Non-Network Maximum Out of Pocket cannot be met with Non-Covered Charges.

Daily Room and Board Limits

During a Period of Hospital Confinement

For semi-private room and board accommodations, Horizon BCBSNJ will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, Horizon BCBSNJ will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable Illness, Horizon BCBSNJ will cover charges up to the Hospital's actual private room charge.

For Special Care Units, Horizon BCBSNJ will cover charges up to the Hospital's actual daily room and board charge.

During a Confinement In An Extended Care Center Or Rehabilitation Center

Horizon BCBSNJ will cover the lesser of:

a. the center's actual daily room and board charge; or

b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Fertility Services
- Nutritional Counseling
- Certain Prescription Drugs

Horizon BCBSNJ will reduce benefits by 50% with respect to charges for treatment, services and supplies which are not Pre-Approved by Horizon BCBSNJ provided that benefits would otherwise be payable under this Policy.

Payment Limits: For Illness or Injury, Horizon BCBSNJ will pay up to the payment limit shown below:

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (combined benefits)	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits) For speech therapy see below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for physical or occupational therapy per Calendar Year (combined benefits) See below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for speech therapy per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for physical and occupational per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (combined benefits)	30 visits

Charges for Preventive Care per Calendar Year as follows:
(Not subject to Copayment, Cash Deductible or Coinsurance)

for a Covered person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age one.	$750 per Covered Person*
for all other Covered Persons	$500 per Covered Person*

*The $750 and$500 limits do not apply to services from a Network Practitioner.

Charges for hearing aids for a Covered Person age 15 or younger	$1,000 per hearing impaired ear per 24-month period
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	Unlimited

I. SCHEDULE OF PREMIUM RATES

The monthly premium rates, in U.S. dollars, for the coverage provided under this Policy are:

Non-Carve Out

Subscriber Only $529.85

Subscriber and Spouse $1,128.06

Subscriber and Family $1,594.51
(including Subscriber, spouse and one or more eligible dependents)

Subscriber and Child(ren) $956.38

Carve Out (Medicare Primary)

Subscriber Only $324.88

Subscriber and Spouse (two over age 65) $649.75

Subscriber and Family (two over age 65) $1,075.24
(including Subscriber, spouse and one or more eligible dependents)

Subscriber and Spouse (one over age 65) $834.14

Subscriber and Family (one over age 65) $1,269.31
(including Subscriber, spouse and one or more eligible dependents)

Subscriber and Child(ren) $696.62

Prescription

Subscriber Only $117.67

Subscriber and Spouse $230.58

Subscriber and Family $266.58
(including Subscriber, spouse and one or more eligible dependents)

Subscriber and Child(ren) $154.65

Horizon BCBSNJ has the right to change any Premium rate(s) set forth above at the times and in the manner established by the provision **Premium Rate Changes** section of this Policy.

GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

a. the forms shown in the Policy Index as of the Effective Date:
b. the Policyholder's application, a copy of which is attached to this Policy;
c. any riders, or amendments to this Policy;
d. the individual applications, if any, of the persons covered.

STATEMENTS

No statement will void the insurance under this Policy, or be used in defense of a claim hereunder unless:

a. in the case of the Policyholder, it is contained in the application signed by the Policyholder; or
b. in the case of a Covered Person, it is contained in a written instrument signed by the Covered Person, and a copy of which is furnished to the Covered Person.

All statements will be deemed representations and not warranties.

INCONTESTABILITY OF THIS POLICY

There will be no contest of the validity of this Policy, except for not paying premiums, after it has been in force for two years from the Effective Date.

No statement in any application, except a fraudulent statement, made by the Policyholder or by a person insured under this Policy shall be used in contesting the validity of his or her insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

AMENDMENT

This Policy may be amended, at any time, without the consent of the Covered Persons or of anyone else with a beneficial interest in it. This can be done through written request made by the Policyholder and agreed to by Horizon BCBSNJ. Horizon BCBSNJ may also make amendments to this Policy, as provided in b. and c. below. Horizon BCBSNJ will give the Policyholder 30 days advance written notice. An amendment will not affect benefits for a service or supply furnished before the date of change.

Only an officer of Horizon BCBSNJ has authority: to waive any conditions or restrictions of this Policy; or to extend the time in which a premium may be paid; or to make or change a Policy; or to bind Horizon BCBSNJ by a promise or representation or by information given or received.

No change in this Policy is valid unless the change is shown in one of the following ways:
a. It is shown in an endorsement on it signed by an officer of Horizon BCBSNJ.
b. In the case of a change in this Policy that has been automatically made to satisfy the requirements of any state or federal law that applies to this Policy, as provided in the

Conformity With Law section, it is shown in an amendment to it that is signed by an officer of Horizon BCBSNJ.

c. In the case of a change required by Horizon BCBSNJ, it is shown in an amendment to it that:

- is signed by an officer of Horizon BCBSNJ; and
- is accepted by the Policyholder as evidenced by payment of a premium becoming due under this Policy on or after the Effective Date of such change.

d. In the case of a written request by the Policyholder for a change, it is shown in an amendment to it signed by the Policyholder and by an officer of Horizon BCBSNJ.

AFFILIATED COMPANIES

If the Policyholder asks Horizon BCBSNJ in writing to include an Affiliated Company under this Policy, and Horizon BCBSNJ gives written approval for the inclusion, Horizon BCBSNJ will treat Employees of that company like the Policyholder's Employees. Horizon BCBSNJ's written approval will include the starting date of the company's coverage under this Policy. But each eligible Employee of that company must still meet all the terms and conditions of this Policy before becoming covered.

An Employee of the Policyholder and one or more Affiliated Companies will be considered an Employee of only one of those Employers for the purpose of this Policy. That Employee's service with multiple Employers will be treated as service with that one.

The Policyholder must notify Horizon BCBSNJ in writing when a company stops being an Affiliated Company. As of this date, this Policy will be considered to end for Employees of that Employer. This applies to all of those Employees except those who, on the next day, are employed by the Policyholder or another Affiliated Company as eligible Employees.

PREMIUM AMOUNTS

The premium due on each premium due date is the sum of the premium charges for the coverage then provided. Those charges are determined from the premium rates then in effect and the Employees and Dependents then covered.

If one or more of the premiums paid include charges for an Employee and/or Dependent whose coverage has ended before the due date of that premium, Horizon BCBSNJ will not be required to refund more than the premiums paid for the two months prior to the date Horizon BCBSNJ receives written notice from the Policyholder that the Employee's and/or Dependents coverage has ended, provided no claims have been incurred during that period. If claims have been incurred during the period prior to Horizon BCBSNJ's receipt of written notice that the Employee and Dependents coverage has ended, Horizon BCBSNJ shall not be required to refund premium to the Policyholder.

PAYMENT OF PREMIUMS - GRACE PERIOD

Premiums are to be paid by the Policyholder to Horizon BCBSNJ. Each may be paid at a Horizon BCBSNJ's office or to one of its authorized agents. A premium payment is due on each premium due date stated on the first page of this Policy. The Policyholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. The Policyholder is liable to pay premiums to Horizon BCBSNJ for the time this Policy is in force.

REINSTATEMENT

If the premium has not been paid before the end of the grace period, this Policy automatically terminates as of the last day of the grace period. The Policyholder may make written request to the Horizon BCBSNJ that the Policy be reinstated. If the Horizon BCBSNJ accepts the request for reinstatement, the Policyholder must pay all unpaid premiums back to the date premium was last paid. Such payment is subject to the premium rate then in effect and to the payment of the reinstatement fee as established by the Horizon BCBSNJ.

PREMIUM RATE CHANGES

The premium rates in effect on the Effective Date are shown in this Policy's Schedule. Horizon BCBSNJ has the right to prospectively change premium rates as of any of these dates:

a. Any premium due date.
b. Any date that an Employer becomes, or ceases to be, an Affiliated Company.
c. Any date that the extent or nature of the risk under this Policy is changed:
    - by amendment of this Policy; or
    - by reason of any provision of law or any government program or regulation; or
    - If this Policy supplements or coordinates with benefits provided by an other insurer, non-profit hospital or medical service plan, or health maintenance organization, on any date Horizon BCBSNJ's obligation under this Policy is changed because of a change in such other benefits.
d. At the discovery of a clerical error or misstatement as described below.

Horizon BCBSNJ will give the Policyholder 60 days advance written notice when a change in the premium rates is made.

PARTICIPATION REQUIREMENTS

At least 75% of the Employees eligible for insurance must be enrolled for coverage. If an eligible Employee is not covered by this Policy because:

a. the Employee is covered as a Dependent under a spouse's coverage, other than individual coverage;
b. the Employee is covered under any fully-insured Health Benefits Plan issued by the same carrier offered by the Policyholder;
c. the Employee is covered under Medicare;
d. the Employee is covered under Medicaid or NJ Family Care; or
e. the Employee is covered under another group health benefits plan.

Horizon BCBSNJ will count this person as being covered by this Policy for the purposes of satisfying participation requirements.

CLERICAL ERROR – MISSTATEMENTS

Neither clerical error nor programming or systems error by the Policyholder, nor the Horizon BCBSNJ in keeping any records pertaining to coverage under this Policy, nor delays in making entries thereon, will invalidate coverage which would otherwise be in force, or continue coverage which would otherwise be validly terminated. However, upon discovery of such error or delay, an equitable adjustment of premiums will be made.

Except as described in the **Premium Amounts** section, premium adjustments involving return of unearned premium to the Policyholder will be limited to the period of 12 months preceding the date of Horizon BCBSNJ's receipt of satisfactory evidence that such adjustments should be made.

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by Horizon BCBSNJ, subject to this Policy's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of this Policy.

TERM OF THE POLICY - RENEWAL PRIVILEGE – TERMINATION

This Policy is issued for a term of one (1) year from the Effective Date shown on the first page of this Policy. All Policy Years and Policy Months will be calculated from the Effective Date. Plan Years will be measured as stated in the definition of Plan Year. All periods of insurance hereunder will begin and end at 12:01 am. Eastern Standard Time at the Policyholder's place of business.

The Policyholder may renew this Policy for a further term of one (1) year, on the first and each subsequent Policy Anniversary. All renewals are subject to the payment of premiums then due, computed as provided in this Policy's **Premium Amounts** section and to the provisions stated below.

Horizon BCBSNJ has the right to non-renew this Policy on the Policy Anniversary following the date the Policyholder no longer meets the requirements of a Small Employer as defined in this Policy. The Policyholder must certify to Horizon BCBSNJ the Policyholder's status as a Small Employer every year. Certification must be given to Horizon BCBSNJ within 10 days of the date Horizon BCBSNJ requests it. If the Policyholder fails to do this, Horizon BCBSNJ retains the right to non-renew this Policy as of the Policyholder's Policy Anniversary.

Horizon BCBSNJ has the right to non-renew this Policy on the Policy Anniversary Date subject to 180 days advance written notice to the Policyholder for the following reasons:

a) subject to the statutory notification requirements, Horizon BCBSNJ ceases to do business in the small group market;
b) subject to the statutory notification requirements, Horizon BCBSNJ ceases offering and non-renews a particular type of Health Benefits Plan in the small group market; or
c) the Board terminates a standard plan or a standard plan option.

Horizon BCBSNJ has the right to non-renew this Policy on the Policy Anniversary Date subject to 60 days advance written notice to the Policyholder for the following reasons:

a) the Policyholder moves outside the state of New Jersey;
b) less than 75% of the Policyholder's eligible Employees are covered by this Policy. If an eligible Employee is not covered by this Policy because:
    1. the Employee is covered as a Dependent under a spouse's coverage, other than individual coverage;
    2. the Employee is covered under any fully-insured Health Benefits Plan issued by the same carrier offered by the Policyholder.
    3. The Employee is covered under Medicare;
    4. The Employee is covered under Medicaid or NJ Family Care; or

5. The Employee is covered under another group health benefits plan, Horizon BCBSNJ will count that Employee as being covered by this Policy for purposes of satisfying participation requirements;

c) the Policyholder does not contribute at least 10% of the annual cost of the Policy; or

d) the Policyholder ceases membership in an association or multiple employer trust, but only if coverage is terminated uniformly, without regard to any Health Status-Related Factor relating to any Covered Person.

If any premium is not paid by the end of its grace period, this Policy will automatically end when that period ends. The Policyholder may write to Horizon BCBSNJ, in advance, to ask that this Policy be ended at the end of the period for which premiums have been paid or at any time during the grace period. Horizon BCBSNJ is not required to honor a request for a retroactive termination of this Policy. For prospective termination requests, this Policy will end on the date requested. The Policyholder is liable to pay premiums to Horizon BCBSNJ for the time this Policy is in force. Horizon BCBSNJ shall give notice of the date of termination to the Policyholder no more than 30 days following the date of the termination.

Immediate cancellation will occur if the Policyholder has performed an act or practice that constitutes fraud, or made an intentional misrepresentation of material fact under the terms of this Policy.

EMPLOYEE'S CERTIFICATE

Horizon BCBSNJ will give the Policyholder an individual certificate of coverage to give each covered Employee. It will describe the Employee's coverage under this Policy. It will include:

a) to whom Horizon BCBSNJ pays benefits;
b) any protection and rights when the coverage ends; and
c) claim rights and requirements.

In the event this Policy is amended, and such amendment affects the material contained in the certificate of coverage, a rider or revised certificate reflecting such amendment will be issued to the Policyholder for delivery to affected Employees.

OFFSET

Horizon BCBSNJ reserves the right, before paying benefits to a Covered Person, to use the amount of payment due to offset a claims payment previously made in error.

CONTINUING RIGHTS

Horizon BCBSNJ's failure to apply terms or conditions does not mean that Horizon BCBSNJ waives or gives up any future rights under this Policy.

ASSIGNMENT BY POLICYHOLDER
Assignment or transfer of the interest of the Policyholder under this Policy will not bind Horizon BCBSNJ without Horizon BCBSNJ's written consent thereto.

CONFORMITY WITH LAW
Any provision of this Policy which is in conflict with the laws of the state in which the Policy is issued, or with Federal law, shall be construed and applied as if it were in full compliance with the minimum requirements of such State law or Federal law.

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on this Policy until 60 days after a Covered Person files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

WORKERS' COMPENSATION
The health benefits provided under this Policy are not in place of, and do not affect requirements for, coverage by Workers' Compensation.

NOTICES AND OTHER INFORMATION
Any notices, documents, or other information under this Policy may be sent by United States mail, postage prepaid addressed as follows:

If to Horizon BCBSNJ: To the last address on record with the Policyholder.

If to a Covered Person: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to Horizon BCBSNJ.

If to the Policyholder: To the last address of the Policyholder on record with Horizon BCBSNJ.

RECORDS - INFORMATION TO BE FURNISHED
Horizon BCBSNJ will keep a record of the Covered Persons. It will contain key facts about their coverage.

At the times set by Horizon BCBSNJ, the Policyholder will send the data required by Horizon BCBSNJ to perform its duties under this Policy, and to determine the premium rates and certify status as a Small Employer. All records of the Policyholder which bear on this Policy must be open to Horizon BCBSNJ for its inspection at any reasonable time.

Horizon BCBSNJ will not have to perform any duty that depends on such data before it is received in a form that satisfies Horizon BCBSNJ. The Policyholder may correct incorrect data given to Horizon BCBSNJ, if Horizon BCBSNJ has not been harmed by acting on it. A person's coverage under this Policy will not be made invalid by failure of the Policyholder, due to clerical error, to record or report the Employee for coverage.

The Policyholder will furnish Horizon BCBSNJ the Employee and Dependents eligibility requirements of this Policy that apply on the Effective Date. Subject to Horizon BCBSNJ's approval, those requirements will apply to the Employee and Dependent coverage under this Policy. The Policyholder will notify Horizon BCBSNJ of any change in the eligibility requirements of this Policy, but no such change will apply to the Employee or Dependent coverage under this Policy unless approved in advance by Horizon BCBSNJ.

The Policyholder will notify Horizon BCBSNJ of any event, including a change in eligibility, that causes termination of a Covered Person's coverage immediately, or in no event later than the last day of the month in which the event occurs. The liability of Horizon BCBSNJ to arrange or provide benefits for a person ceases when the person's coverage ends under this Policy. If the Policyholder fails to notify Horizon BCBSNJ as provided above, Horizon BCBSNJ will be entitled to reimbursement from the Policyholder of any benefits paid to any person after the person’s coverage should have ended.

CLAIMS PROVISIONS

A claimant's right to make a claim for any benefits provided by this Policy is governed as follows:

PROOF OF LOSS

Proof of loss must be sent to Horizon BCBSNJ within 90 days of the loss. If a notice or proof is sent later than 90 days of the loss, Horizon BCBSNJ will not deny or reduce a claim if the notice or proof was sent as soon as possible.

PAYMENT OF CLAIMS

Horizon BCBSNJ will pay all benefits to which the claimant is entitled as soon as Horizon BCBSNJ receives written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the Covered Person's death will be paid as soon as Horizon BCBSNJ receives due proof of the death to one of the following:

a) his or her estate;
b) his or her spouse;
c) his or her parents;
d) his or her children;
e) his or her brothers and sisters; or
f) any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct Horizon BCBSNJ, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. For covered services from an eligible Facility or Practitioner, Horizon BCBSNJ will determine to pay either the Covered Person or the Facility or the Practitioner. The Employee may not assign his or her right to take legal action under this Policy to such provider.

PHYSICAL EXAMS

Horizon BCBSNJ, at its expense, has the right to examine the insured. This may be done as often as reasonably needed to process a claim. Horizon BCBSNJ also has the right to have an autopsy performed, at its expense.

DEFINITIONS

The words shown below have special meanings when used in this Policy. Please read these definitions carefully. Throughout this Policy, these defined terms appear with their initial letter capitalized.

Accredited School means a school accredited by a nationally recognized accrediting association, such as one of the following regional accrediting agencies: Middle States Association of Colleges and Schools, New England Association of Schools and Colleges, North Central Association of Colleges and Schools, Northwest Association of Schools and Colleges, Southern Association of Colleges and Schools, or Western Association of Schools and Colleges. An accredited school also includes a proprietary institution approved by an agency responsible for issuing certificates or licenses to graduates of such an institution.

Actively at Work or **Active Work** means performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Policyholder's place of business, or at any other place that the Policyholder's business requires the Employee to go.

Affiliated Company means a company as defined in subsections (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986. All entities that meet the criteria set forth in the Internal Revenue Code shall be treated as one employer.

Allowed Charge means an amount that is not more than the lesser of:
- the allowance for the service or supply as determined by Horizon BCBSNJ, based on a standard approved by the Board; or
- the negotiated fee schedule.

The Board will decide a standard for what is an Allowed Charge under this Policy. For charges that are not determined by a negotiated fee schedule, the Covered Person may be billed for the difference between the Allowed Charge and the charge billed by the Provider.

Please note: The Coordination of Benefits and Services provision includes a distinct definition of Allowed Charge.

Ambulance means a certified transportation vehicle for transporting Ill or Injured people that contains all life-saving equipment and staff as required by state and local law.

Ambulatory Surgical Center means a Facility mainly engaged in performing Outpatient Surgery. It must:
a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b) have permanent operating and recovery rooms;
c) be staffed and equipped to give emergency care; and
d) have written back-up arrangements with a local Hospital for emergency care.

Horizon BCBSNJ will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
b) approved for its stated purpose by Medicare.

Horizon BCBSNJ does not recognize a Facility as an Ambulatory Surgical Center if it is part of a Hospital.

Anniversary Date means the date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

Approved Cancer Clinical Trial means a scientific study of a new therapy or intervention for the treatment, palliation, or prevention of cancer in human beings that meets the following requirements:

a) The treatment or intervention is provided pursuant to an approved cancer clinical trial that has been authorized or approved by one of the following: 1) The National Institutes of Health (Phase I, II and III); (2) the United States Food and Drug Administration, in the form of an investigational new drug (IND) exemption (Phase I, II and III); 3) The United States Department of Defense; or 4) The United States Department of Veteran Affairs.
b) The proposed therapy has been reviewed and approved by the applicable qualified Institutional Review Board.
c) The available clinical or pre-clinical data to indicate that the treatment or intervention provided pursuant to the Approved Cancer Clinical Trial will be at least as effective as standard therapy, if such therapy exists, and is expected to constitute an improvement in effectiveness for treatment, prevention and palliation of cancer.
d) The Facility and personnel providing the treatment are capable of doing so by virtue of their experience and training.
e) The trial consists of a scientific plan of treatment that includes specified goals, a rationale and background for the plan, criteria for patient selection, specific directions for administering therapy and monitoring patients, a definition of quantitative measures for determining treatment response and methods for documenting and treating adverse reactions. All such trials must have undergone a review for scientific content and validity, as evidenced by approval by one of the federal entities identified in item a. A cost-benefit analysis of clinical trials will be performed when such an evaluation can be included with a reasonable expectation of sound assessment.

Birthing Center means a Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b) be staffed and equipped to give emergency care; and
c) have written back-up arrangements with a local Hospital for emergency care.

Horizon BCBSNJ will recognize it if:

a) it carries out its stated purpose under all relevant state and local laws; or
b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c) it is approved for its stated purpose by Medicare.

Horizon BCBSNJ does not recognize a Facility as a Birthing Center if it is part of a Hospital.

Board means the Board of Directors of the New Jersey Small Employer Health Benefits Program.

Calendar Year means each successive 12 month period which starts on January 1 and ends on December 31.

Cash Deductible means the amount of Covered Charges that a Covered Person must pay before this Policy pays any benefits for such charges. Cash Deductible does not include Coinsurance, Copayments and Non-Covered Charges. See the **Cash Deductible** section of this Policy for details.

Church Plan has the same meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974".

Coinsurance means the percentage of a Covered Charge that must be paid by a Covered Person. Coinsurance does **not** include Cash Deductibles, Copayments or Non-Covered Charges.

Copayment means a specified dollar amount a Covered Person must pay for specified Covered Charges. **Note**: The Emergency Room Copayment, if applicable, must be paid in addition to the Cash Deductible, any other Copayments, and Coinsurance.

Cosmetic Surgery or Procedure means any surgery or procedure which involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate.

Covered Charges are Allowed charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of this Policy. The services and supplies must be:

a) furnished or ordered by a recognized health care Provider; and
b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of this Policy, Horizon BCBSNJ pays benefits for Covered Charges incurred by a Covered Person while he or she is insured by this Policy. Read the entire Policy to find out what Horizon BCBSNJ limits or excludes.

Covered Person means an eligible Employee or a Dependent who is insured under this Policy.

Creditable Coverage means, with respect to an Employee or Dependent, coverage of the Employee or Dependent under any of the following: A Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); Title XXI of the Social Security Act (State Children's Health Insurance Program), chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code; a Public Health Plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act"; or coverage under any other type of plan as set forth by the Commissioner of Banking and Insurance by regulation.

Creditable Coverage does not include coverage which consists solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of Health Benefits Plan.

Current Procedural Terminology (C.P.T.) means the most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

Custodial Care means any service or supply, including room and board, which:
a) is furnished mainly to help a person meet his or her routine daily needs; or
b) can be furnished by someone who has no professional health care training or skills.

Even if a Covered Person is in a Hospital or other recognized Facility, Horizon BCBSNJ does not pay for that part of the care which is mainly custodial.

Dependent means an Employee's:

a) legal spouse which shall include a civil union partner pursuant to P.L. 2006, c. 103 as well as same sex relationships legally recognized in other jurisdictions when such relationships provide substantially all of the rights and benefits of marriage. .and domestic partner pursuant to P.L. 2003, c. 246;; except that legal spouse shall be limited to spouses of a marriage as marriage is defined in the Federal Defense of Marriage Act, 1 U.S.C.A. 7, with respect to:
   - the provisions of the Policy regarding continuation rights required by the Federal Consolidated Omnibus Reconciliation Act of 1986 (COBRA), Pub. L. 99-272, as subsequently amended. (Neither domestic partners nor civil union partners have COBRA rights.) and
   - the provisions of this Policy regarding Medicare Eligibility by reason of Age and Medicare Eligibility by Reason of Disability.

b) Dependent child who is under age 26.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Dependent Coverage** section of this Policy.

An Employee's " Dependent child" includes:
a) his or her legally adopted children,
b) his or her step-child,
c) the child of his or her civil union partner, and

d) the child of his or her domestic partner, and
e) children under a court appointed guardianship.

Horizon BCBSNJ treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. Horizon BCBSNJ treats such a child this way whether or not a final adoption order is ever issued.

Dependent's Eligibility Date means the later of:
a) the Employee's Eligibility Date; or
b) the date the person first becomes a Dependent.

Developmental Disability or Developmentally Disabled means a severe, chronic disability that:
a) is attributable to a mental or physical impairment or a combination of mental and physical impairments;
b) is manifested before the Covered Person:

1. attains age 22 for purposes of the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision; or
2. attains age 26 for all other provisions;

c) is likely to continue indefinitely;
d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; economic self-sufficiency;
e) reflects the Covered Person's need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are of lifelong or of extended duration and are individually planned and coordinated. Developmental Disability includes but is not limited to severe disabilities attributable to mental retardation, autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met.

Diagnostic Services means procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:
a) radiology, ultrasound and nuclear medicine;
b) laboratory and pathology; and
c) EKGs, EEGs and other electronic diagnostic tests.

Except as allowed under the Preventive Care Covered Charge, Diagnostic Services are not covered under this Policy if the procedures are ordered as part of a routine or periodic physical examination or screening examination.

Discretion / Determination / Determine means the Horizon BCBSNJ's sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

Durable Medical Equipment is equipment which is:

a) designed and able to withstand repeated use;
b) primarily and customarily used to serve a medical purpose;
c) generally not useful to a Covered Person in the absence of an Illness or Injury; and
d) suitable for use in the home.

Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and apnea monitors.

Among other things, Durable Medical Equipment does not include adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to the home or place of business, waterbeds, whirlpool baths and exercise and massage equipment.

Effective Date means the date on which coverage begins under this Policy for the Policyholder, or the date coverage begins under this Policy for an Employee or Dependent, as the context in which the term is used suggests.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of Substance Abuse such that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of immediate medical attention to result in: placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or

part. With respect to a pregnant woman who is having contractions, an emergency exists where: there is inadequate time to effect a safe transfer to another Hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or unborn child.

Employee means a Full-Time bona fide Employee (25 hours per week) of the Policyholder. Partners, proprietors, and independent contractors will be treated like Employees, if they meet all of this Policy's conditions of eligibility. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of this Policy.

Employee's Eligibility Date means the later of:
a) the date of employment; or
b) the day after any applicable waiting period ends.

Employer means MICHAEL S. LIBOCK, CPA, LLC

Enrollment Date means, with respect to a Covered Person, the Effective Date or, if earlier, the first day of any applicable waiting period. If an Employee changes plans or if the Employer transfers coverage to another carrier, the Covered Person's Enrollment Date does not change.

Experimental or Investigational means Horizon BCBSNJ determines a service or supply is:
a) not of proven benefit for the particular diagnosis or treatment of a particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or
c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for treatment for which the drug has not been approved by the United States Food and Drug Administration (FDA), Horizon BCBSNJ will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

Horizon BCBSNJ will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition, as explained below.

Horizon BCBSNJ will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

1. The American Hospital Formulary Service Drug Information; or
2. The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study or recommended by a review article in a major peer reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

c. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

d. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

e. Proof as reflected in the published peer reviewed medical literature must exist that improvements in health outcomes; as defined item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

Extended Care Center means a Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. Horizon BCBSNJ will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a) accredited for its stated purpose by the Joint Commission; or
b) approved for its stated purpose by Medicare. In some places, an "Extended Care Center" may be called a "Skilled Nursing Facility."

Facility means a place Horizon BCBSNJ is required by law to recognize which:

a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
b) provides health care services which are within the scope of its license, certificate or accreditation.

Full-Time means a normal work week of 25 or more hours. Work must be at the Policyholder's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

Government Hospital means a Hospital operated by a government or any of its subdivisions or agencies, including but not limited to a Federal, military, state, county or city Hospital.

Group Health Plan means an employee welfare benefit plan, as defined in Title I of section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (ERISA) (29 U.S.C. §1002(1)) to the extent that the plan provides medical care and includes items and services paid for as medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.

Health Benefits Plan means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992. c. 162 (C. 17B: 27A-19) or any other similar contract, policy, or plan issued to a Small Employer, not explicitly excluded from the definition of a health benefits plan. Health Benefits Plan does not include one or more, or any combination of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health Benefits Plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long term care, nursing home care, home health care, community based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health Benefits Plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group Health Benefits Plan maintained by the same Plan Sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any Group Health Plan maintained by the same Plan Sponsor. Health Benefits Plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act; and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health Plan.

Health Status-Related Factor means any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

Home Health Agency means a Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. Horizon BCBSNJ will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

Hospice means a Provider which provides palliative and supportive care for terminally Ill or terminally Injured people under a hospice care program. Horizon BCBSNJ will recognize a hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:

a) approved for its stated purpose by Medicare; or
b) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospital means a Facility which mainly provides Inpatient care for Ill or Injured people. Horizon BCBSNJ will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a) accredited as a Hospital by the Joint Commission; or
b) approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent home, rest or nursing Facility, or a Facility, or part of it which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance abusers is also not a Hospital.

Illness or Ill means a sickness or disease suffered by a Covered Person or a description of a Covered Person suffering from a sickness or disease. Illness includes Mental Illness.

Initial Dependent means those eligible Dependents an Employee has at the time he or she first becomes eligible for Employee coverage. If at the time the Employee does not have any eligible Dependents, but later acquires them, the first eligible Dependents he or she acquires are his or her Initial Dependents.

Injury or Injured means all damage to a Covered Person's body and all complications arising from that damage, or a description of a Covered Person suffering from such damage.

Inpatient means a Covered Person who is physically confined as a registered bed patient in a Hospital or other recognized health care Facility; or services and supplies provided in such settings.

Joint Commission means the Joint Commission on the Accreditation of Health Care Organizations.

Late Enrollee means an eligible Employee or Dependent who requests enrollment under this Policy more than 30 days after first becoming eligible. However, an eligible Employee **or a Dependent** will not be considered a Late Enrollee under certain circumstances. See the **Employee Coverage and Dependent Coverage sections** of this Policy.

Medically Necessary and Appropriate means that a service or supply is provided by a recognized health care Provider, and Horizon BCBSNJ determines at its Discretion, that it is:

a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b) provided for the diagnosis, or the direct care and treatment, of the condition, Illness or Injury;
c) in accordance with generally accepted medical practice;
d) not for the convenience of a Covered Person;
e) the most appropriate level of medical care the Covered Person needs; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

Medicaid means the health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

Medicare means Parts A and B of the health care program for the aged and disabled provided by Title **XVIII** of the United States Social Security Act, as amended from time to time.

Mental Health Center means a Facility which mainly provides treatment for people with Mental Illness. Horizon BCBSNJ will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) accredited or licensed by the state of New Jersey to provide mental health services.

Mental Illness means a behavioral, psychological or biological dysfunction. Mental illness includes a biologically-based mental illness as well as a mental illness that is not biologically-based. With respect to mental illness that is biologically based, mental illness means a condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder and pervasive developmental disorder or autism.

The current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association may be consulted to identify conditions that are considered mental illness.

Newly Acquired Dependent means an eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.

Nicotine Dependence Treatment means "Behavioral Therapy," as defined below, and Prescription Drugs which have been approved by the U.S. Food and Drug Administration for the management of nicotine dependence.

For the purpose of this definition, covered "Behavioral Therapy" means motivation and behavior change techniques which have been demonstrated to be effective in promoting nicotine abstinence and long term recovery from nicotine addiction.

Non-Covered Charges are charges which do not meet this Policy's definition of Covered Charges or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Charges or are otherwise not covered by this Policy.

Nurse means a registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b) provides medical services which are within the scope of his or her license or certificate.

Orthotic Appliance means a brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

Outpatient means a Covered Person who is **not** confined as a registered bed patient in a Hospital or recognized health care Facility and is not an Inpatient; or services and supplies provided in such Outpatient settings.

Period of Confinement means consecutive days of Inpatient services provided to an Inpatient or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. Horizon BCBSNJ determines if the cause(s) of the confinements are the same or related.

Plan means the Horizon BCBSNJ's group health benefit plan purchased by the Employer.

Planholder means the Employer who purchased group health benefit plan.

Plan Sponsor has the meaning given that term under Title I, section 3 of Pub.L.93-406, the ERISA (29 U.S.C. §1002(16)(B)). That is:

a) the Small Employer in the case of an employee benefit plan established or maintained by a single employer;
b) the employee organization in the case of a plan established or maintained by an employee organization; or
c) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

Plan Year means the year that is designated as the plan year in the plan document of a Group Health Plan, except if the plan document does not designate a plan year or if there is no plan document, the Plan Year is a Calendar Year.

Policy means this group policy, including the application and any riders, amendments, or endorsements, between the Employer and Horizon BCBSNJ.

Policyholder means the Employer who purchased this Policy.

Practitioner means a person Horizon BCBSNJ is required by law to recognize who:

a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b) provides medical services which are within the scope of his or her license or certificate.

For purposes of Applied Behavior Analysis as included in the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision, Practitioner also means a person who is credentialed by the national Behavior Analyst Certification Board as either a Board Certified Behavior Analyst – Doctoral or as a Board Certified Behavior Analyst.

Pre-Approval or Pre-Approved means the Horizon BCBSNJ's approval using paper or electronic means for specified services and supplies prior to the date charges are incurred. Horizon BCBSNJ will reduce benefits by 50% with respect to charges for treatment, services and supplies which require Pre-Approval and are not Pre-Approved by Horizon BCBSNJ provided that benefits would otherwise be payable under this Policy.

Pre-Existing Condition means, for a Covered Person age 19 or older, an Illness or Injury which manifests itself in the six months before a Covered Person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.